

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson St, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-296-0803



IMMUNIZATION REPORT FORM

Type of facility: ☐ Child Care Center ☐ Preschool ☐ Head Start Center ☐ School Age Program

License Number: _____

Name of Facility exactly as it appears on the license _____ Date _____

Address of Facility _____
Street City Zip Code County

Please list the initials of children presently receiving care in this facility. Write the month, day and year (MM/DD/YY) of each immunization completed in each series in the box below. Please do not place a check mark in the box.

Initials	Date of Birth	DPT					ORAL POLIO				MMR		HIB*				HBV*			VAR*	
		1	2	3	4	5	1	2	3	4	1	2	1	2	3	4	1	2	3	1	

*Recommended Immunizations

Facility Name AS IT APPEARS ON THE LICENSE.

Date

[illegible]

*Recommended Immunizations